Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4876AGZ	A. BUILDING _____ B. WING _____	04/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN GROUP HOME INC	3696 S PECOS ROAD LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on April 28, 2009 and completed on April 29, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for ten Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was seven. Seven resident files were reviewed and five employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of D. The following deficiencies were identified:	Y 000		
Y 085 SS=I	449.199(1) Staffing-CG on duty all times NAC 449.199 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility.	Y 085		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 085	Continued From page 1	Y 085		

This Regulation is not met as evidenced by:
Based on observation, interview and record review from 4/28/09 to 4/29/09, the administrator failed to ensure that at least one caregiver was on the premise to care for and provide protective supervision for 7 of 7 residents (Resident #1, #2, #3, #4, #5, #6 and #7).

Findings include:

On April 28, 2009 at 8:05 AM, the surveyor arrived at the facility to begin an annual survey. The door was answered by a man who indicated he was not a caregiver. When asked if there was a caregiver, he pointed to a woman in the dining room. The woman introduced herself by name then went back into the kitchen to finish cooking breakfast for the five residents sitting at the dining room table.

At 8:20 AM, Resident #3 was observed in bed with bilateral full side rails in the highest position. The resident was lying in a wet bed from her knees to her neck. When the resident was asked if she spilled water, she indicated she had urinated in bed and no one had come to clean her up. When the resident was asked if she was hungry and if she would be getting out of bed to eat, the resident reported she needed help to get out of bed. The woman working in the kitchen was notified that the resident needed to be cleaned up. The woman stated that hospice staff would be at the facility at 8:30 AM to get the resident cleaned up and out of bed so the resident could eat breakfast.

At 8:25 AM, the surveyor walked into the dining room. The April schedule was posted on a cork

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Y 085	Continued From page 2	Y 085		

board. The name of the woman working in the kitchen was not on the staffing schedule. When asked why her name was not on the schedule, the woman indicated she was a volunteer. The woman further revealed she volunteered five days a week and stayed in the facility for four nights a week. The woman also stated she talked with the residents, took the residents outside and helped with the cooking and sometimes performed housekeeping duties. The volunteer stated that Employee #4 was the caregiver on duty, but the employee left the facility at 7:30 AM to go out to breakfast and had not returned yet.

At 8:35 AM, Employee #4 returned back to the facility. The employee revealed his wife had car trouble and he had to go help. This account for his absence differed from the account given to the surveyor by the woman cooking in the kitchen. At 8:45 AM, Employee #4 was informed of Resident #3's condition and he stated he would go and clean her up.

Later in the survey, Employee #4 was again interviewed about why there was no caregiver on the premise at the beginning of the survey. The employee indicated he left the facility at 7:45 AM. When he left, he thought Employee #3 was on his way. When questioned why he thought the employee was on the way, Employee #4 revealed he called Employee #3 around 7:40 AM or 7:45 AM. Employee #3 did not tell Employee #4 where he was or when he would arrive to the facility. Employee #4 indicated he thought Employee #3 would be there in 15 minutes. When asked again why he did not wait, Employee #4 indicated his wife was having car trouble and she needed to get to work. The employee revealed he picked her up and dropped her off at her work then he

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Y 085	Continued From page 3 drove back to the facility. On 4/29/09, Employee #5 reported the volunteer had been left alone in the facility on occasion (maybe one time a week). Later, the employee then rescinded the statement indicating there was always an employee in the facility. Residents were interviewed on 4/29/09 regarding being left alone without caregivers. Two oriented residents verified that the residents had been left alone on more than one occasion. One resident indicated there were times the residents were left alone without staff, but staff would always tell her when they were leaving the facility. She indicated she would get scared when left alone. Another resident initially refused to talk with the surveyor on 4/28/09, but agreed to talk the next day (4/29/09). The resident indicated she had been left alone without a caregiver at times. Without a caregiver on the premises at all times, the facility can not provide protective supervision to residents nor provide care. Severity: 3 Scope: 3	Y 085		
Y 557 SS=D	449.262(3)(a) Restriction on Use of Restraints NAC 449.262 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident. This Regulation is not met as evidenced by: Based on observation and interview on 4/28/09, the facility failed to ensure restraints were not utilized for 2 of 7 residents (full bed rails used for	Y 557		

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Y 557	Continued From page 4 Resident #2 and #3). Severity: 2 Scope: 1	Y 557		
Y 870 SS=F	449.2742(1)(a)(1)(2)(b)(c) 449.2742(1)(a)(1) Medication Administration NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. (2) Provides a written report of that review to the administrator of the facility; (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). This Regulation is not met as evidenced by: Based on record review on 4/28/09, the facility	Y 870		

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Y 870	Continued From page 5 did not ensure that a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 4 of 5 residents residing in the facility for longer than six months (Resident #1, #2, #5 and #7). Severity: 2 Scope: 3	Y 870		
Y 878 SS=F	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review and interview on 4/28/09, the facility failed to ensure that 4 of 7 residents received medications as prescribed (Resident #1, #2, #4 and #6). Severity: 2 Scope: 3	Y 878		
Y 923 SS=F	449.2748(3)(b) Medication Container	Y 923		

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Y 923	Continued From page 6 NAC 449.2748 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (b) Kept in its original container until it is administered. This Regulation is not met as evidenced by: Based on observation on 4/28/09 and 4/29/09, the facility failed to keep medications belonging to 7 of 7 residents in their original container (Resident #1, #2, #3, #4, #5, #6 and #7). Severity: 2 Scope: 3	Y 923		
Y 992 SS=I	449.2756(1)(c) Alzheimer's Fac awake staff NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. This Regulation is not met as evidenced by: Based on observation and interview on 4/29/09, the facility failed to ensure one member of the staff was awake at the facility at all times (Employee #5).	Y 992		

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Y 992	Continued From page 7 Findings include: April 29, 2009 at 6:40 AM, the surveyor arrived at the facility to retrieve copies of the employee schedule. The door was opened by the volunteer. She indicated the only staff in the facility was Employee #5. She went to the back bedroom to notify the employee the surveyor had arrived. Resident #1, #5 and #7 were awake. Resident #1 was sitting outside and the other two residents were sitting around the dining room table. At 6:45 AM, Employee #5 came out of the bedroom. He indicated he worked last night. When asked when he was able to sleep, he replied he went to sleep at 10:30 PM and woke up at 5:30 AM. The employee revealed he worked nights except for Fridays. When asked how he could take care of residents while sleeping, the employee stated he would only wake up when residents called out at night. Severity: 3 Scope: 3	Y 992		
Y 994 SS=F	449.2756(1)(e) Alzheimer's fac knives NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents.	Y 994		

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Y 994	Continued From page 8 This Regulation is not met as evidenced by: Based on observation on 4/28/09, a knife used to prepare breakfast was left unattended in the kitchen and was accessible to 7 of 7 residents. Severity: 2 Scope: 3	Y 994		